

**Opportunities for Kentucky to Address  
Substance Abuse in Pregnancy and Substance Exposed Infants  
A Report from the Maternal and Infant Substance Abuse Workgroup  
October 29, 2012**

**EXECUTIVE SUMMARY**

Substance abuse is increasingly becoming a threat to our nation's health and well-being, a true public health epidemic. Kentucky leads the nation in prescription drug abuse. Of particular concern to our state and to our nation is the abuse of these drugs during pregnancy, putting a significant number of Kentucky's children at risk not only from direct toxic effects of these substances, but also from the dysfunctional family environment that they are surrounded by after birth and during the critical early years of development. Only a percentage of these substance exposed infants (SEI) go through withdrawal after birth (Neonatal Abstinence Syndrome, NAS), but increasingly these infants are filling the beds of the state's NICU's.

A workgroup of experts from many disciplines met in August, 2012 to discuss what interventions Kentucky should consider to address this issue. Information collected before, during, and after this meeting has led to this paper outlining recommendations for consideration to enhance KY's efforts to address substance abuse in pregnant women and substance exposed newborns.

**SUMMARY OF RECOMMENDATIONS:**

- A. Address primary prevention with adolescents (e.g. SAMSHA "Communities that Care" model or Anne E. Casey "Communities of Hope").
- B. Consider extending coverage for mental health and substance abuse services to women of childbearing age < 185% of poverty (before and between pregnancies).
- C. Develop Consensus KY Guidelines for Prenatal Care of Women with Substance Abuse.
- D. Develop a Universal Screening for pregnant women and a referral System for positive screens.
- E. Implement Screening, Brief Intervention, Referral to Treatment (SBIRT) in provider offices by providing Medicaid payment and trainings for this service.
- F. Hospitals should develop a protocol for testing infants at risk.
- G. Develop Consensus Guidelines for Management of NAS.
- H. Build systems of Support for the mother/caregiver and the infant through the first 2-3 years.
- I. Extend and Focus KIDS NOW Substance abuse in pregnancy program on case management.
- J. Develop support for Grandparents caring for Substance Exposed Infants.
- K. Develop a system of ready access to health care professionals & supports for affected families.
- L. Increase awareness of substance abuse needs in the child welfare system.
- M. Host a Governor's Summit on this topic to create a unified ACTION AGENDA.
- N. Establish a coordinating body to implement the Action Agenda.
- O. Leverage Medicaid options.
- P. Establish baseline measures for monitoring this problem.
- Q. Increase access to and oversight of Medication Assisted Treatment within Opioid Treatment Programs.
- R. Increase the residential treatment facilities available for pregnant women/women with children.

DRAFT

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**Section 1: SCOPE OF THE PROBLEM**

Substance abuse is increasingly becoming a threat to our nation's health and well-being, a true public health epidemic. Conservatively, the rates of substance abuse in the nation, particularly the abuse of prescription drugs, have at least tripled over the last decade. According to the CDC, drug overdoses have now overtaken motor vehicle accidents as the leading cause of death.

For Kentucky, this is yet another health issue where we are at the worst end of the ranking of states. Kentucky leads the nation in:

- the number of prescriptions for controlled substances per person (KASPER, 2011)
- % of Kentuckians (8.5%) using psychotherapeutic drugs for non-medical reasons
- % of Kentuckians (7%) using prescription pain meds [Darvon, Percodan] for non-medical reasons
- % of Kentuckians (4.6%) using prescription tranquilizers [Valium, Xanax] for non-medical reasons
- % of Kentuckians (2%) using prescription stimulants for non-medical reasons,
- And is second in the nation in rates of smoking [alcohol use?]

Of particular concern to our state and to our nation is the abuse of these drugs during pregnancy, putting a significant number of Kentucky's children at risk not only from direct toxic effects of these substances, but also from the dysfunctional family environment that they are surrounded by after birth and during the critical early years of development. The vulnerability of the fetal and infant brain, the hardwiring of social-emotional and cognitive capacity, and the ability of the child to function in society in the future are affected by both the drugs and the toxic stress surrounding a child in that culture. These children begin life with two strikes against them, and have higher rates of inability to function as they grow older. Substance-exposed infants and children have been shown to have higher rates of early mental health and behavioral problems, as well as higher rates of adverse birth outcomes, and increased health care utilization after discharge.<sup>2</sup> SEIs are at higher risk of coming into contact with the child welfare system at some point, and findings regarding children in foster care indicate that most children do not actually receive the assessments and services they need.<sup>3</sup> Referring all substance-exposed infants to child welfare agencies would easily overwhelm the system but clearly the safety of these infants is a concern.

In Kentucky, the prevalence of substance-exposed infants (SEI) and mothers abusing substances during pregnancy is unknown. Estimates from prevalence studies in other nearby states and from Kentucky hospitals doing universal screening would suggest at least 10% and up to 60% of newborns are drug exposed due to substance abuse during pregnancy. [This does not include smoking rates]. However, only a portion of these infants will develop withdrawal symptoms (Neonatal Abstinence Syndrome, NAS), and many of those will not develop symptoms during the typical 48 hrs of hospitalization after birth. It is difficult to know if we should worry more about the

babies who develop NAS and get treated in an NICU, and have opportunities for intervention, or those who never have symptoms and never get flagged as being at risk. That being said, diagnoses of NAS in Kentucky have risen exponentially over the last decade – from 29 in 2000 to 730 in 2011 (CHFS, 2012). While some of this can be attributable to better recognition and coding, there is no denying this dramatic increase. Medicaid-covered births are disproportionately represented in these cases. Nationally, using 2009 data, 77.6% of charges for NAS were attributed to state Medicaid programs, with mean hospital charges of \$53,400 per case.<sup>4</sup> In developing policy around maternal substance abuse and substance-exposed infants, the context must include current science around this topic:

- “Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes...”<sup>5</sup>
- Although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction.”<sup>5</sup>
- Substance abuse is a symptom, and most often occurs with a constellation of other conditions such as depression and domestic violence. If we treat the substance abuse but do not address the underlying issues, then we are not likely to see sustained changes.
- Smoking remains the single most preventable cause of mortality and morbidity in mothers and babies in the US [CDC], even though rates of substance abuse may now be as high or higher than smoking rates
- *Smoking and Alcohol do more damage to the developing fetus than all the other abused substances [combined]*
- Poly drug use is common.
- Nicotine and alcohol use are markers for other drug abuse.
- Treatment of Substance abuse works – up to 80% of pregnant women can be “clean” at delivery.<sup>6</sup>
- Pregnancy enhances long term recovery – up to 65% who get off drugs in pregnancy are still abstinent after 1 year.<sup>6</sup>
- Brief Intervention by a physician has been shown to be effective.
- Patients who abuse substances during pregnancy should be treated non-judgmentally. Seeking OB care should not expose a woman to civil or criminal penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.<sup>5</sup>
- NAS may correlate better with degree of smoking than amount of opioid treatment.

“To fully address SEI issues, they must be handled in an intensely collaborative setting, since no single agency has the resources, the information base, or the lead role to address the full range of needs of all substance-exposed or substance-affected newborns and their families.”<sup>1</sup>

**The following are recommendations for ways Kentucky might better address substance abuse in pregnancy and substance-exposed infants:**

## **Section 2: INTERVENTION FRAMEWORK**

### **1. PRE-PREGNANCY/ INTERPREGNANCY**

- A. Address primary prevention with Adolescents. “Adolescence is a period of neurodevelopmental vulnerability for developing addictions; age at first use is inversely correlated with lifetime incidence of developing addictions.”<sup>7</sup> Recent studies indicate the current generation’s abuse of prescription pain medications is higher than any generation in history.<sup>8</sup> KY data indicates that 24.4% of Kentucky high school students have been offered, sold, or given illegal drugs by someone on school property (YRBS, 2011).
- Encourage KY ASAP boards and DCBS Community Collaborations for Children to use SAMSHA’s “Communities that Care” model for community substance abuse coalitions to implement evidence-based strategies appropriate for their communities. The Communities that Care model is used in over 300 communities nation-wide and saves \$5.30 for every \$1 spent.<sup>9</sup> Another model may be the “Community of Hope” model being implemented in Johnson County, funded by Anne E. Casey.
- B. Utilize Screening, Brief Intervention, and Treatment (SBIRT) in pediatrician offices as recommended by AAP, by providing Medicaid payment for this service.
- “Turning on” the Medicaid code for SBIRT would allow pediatricians to do screening and brief interventions with this population as recommended by AAP.
- C. Consider extending coverage for mental health and substance abuse services for women of childbearing age. To have a healthy pregnancy, women must be healthy before becoming pregnant. This includes being free from substance abuse and addressing mental health issues. Ninety percent of opioid abuse in females is in women of childbearing age.<sup>10</sup> The state should consider a Medicaid waiver similar to the proposed Family Planning state plan amendment that would provide payment for mental health and substance abuse services for all women < 185% of poverty, before and between pregnancies. Since substance abuse is linked to depression, mental health issues, and domestic violence, all should be covered.

### **2. PRENATAL – Prenatal interventions such as the ones listed below to identify substance abuse in pregnancy early, get women into treatment, and minimize the adverse effects of these substances on the newborn.**

- A. Develop Consensus KY Guidelines for Prenatal Care of Women with Substance Abuse. ACOG has a number of practice bulletins and committee opinions on this subject. Maternal-Fetal Medicine specialists on the workgroup have agreed to lead these discussions. Tentatively we are planning to provide a forum for this work at the ACOG/Substance abuse meeting on March 14 and 15. Controversies include:
- Should the care of these pregnant women be primarily with the OB and not the addiction specialists (less confusing, more consistent for the woman)?
  - What supports are in place for pregnant women who are getting medication?
  - Do KY pregnant women get treated with larger doses of methadone than in other states?
  - Should pregnant women be weaned/tapered during the pregnancy as long as there is a plan in place for relapse?
  - Does suboxone have benefits for the baby over methadone?

- B. Implement Universal Screening early in pregnancy and Develop a Referral Network/System. ACOG recommends “All women should be screened early in pregnancy for substance use, including prescription drug abuse, with a validated questionnaire.”<sup>11</sup> However, ACOG also clearly states “drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus. Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing.”<sup>5</sup> Universal screening as a routine part of prenatal care is recommended because “although the type of drug may differ, individuals from all races and socioeconomic strata have similar rates of substance abuse and addiction.”<sup>5</sup>
- i. Tool development: Current workgroup could develop a universal screening form modeled after the WV Universal risk screening tool and encourage voluntary use. A few hospitals in KY already routinely screen all pregnant women for substance abuse.
  - ii. Referral Network Development: Providers have no reason to screen unless there is some place to refer those who screen positive. The workgroup would have to determine how to collect the information and assure referral and treatment resources are available in a timely manner. Modifying the current KIDS NOW PLUS case management program for substance-abusing pregnant women is one possibility for accepting these referrals from OB’s who do screening.
  - iii. Consider Legislated Universal Screening: Once resources and decision trees for referrals are established, state could consider legislation and funding to support a Universal Maternal Risk Screening program similar to the 2009 West Virginia model that is considered a best practice.<sup>12</sup>
- C. Screening, Brief Intervention, Referral to Treatment (SBIRT) in provider offices. It is recommended that prenatal care providers utilize the evidence-based practice, *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) universally with their pregnant patients in order to identify risk of substance use, mental health problems, and intimate partner violence, and intervene as indicated by the screen. A referral system to accept those who screen positive would be necessary. SBIRT could be a mandatory service for all prenatal patients funded by Medicaid and private insurance, and SBIRT could be an element of the Essential Health Benefit package for Kentucky’s Health Insurance Exchange.
- i. Louisiana Birth Outcomes Initiative is currently piloting such a model where all OB providers do the screening and brief intervention, and are paid for it through Medicaid (for Medicaid eligible women).<sup>13</sup> There is an existing Medicaid code for SBIRT that states have the option to “turn on”.
  - ii. Other options include providing these services by staff in the provider office. In Ky’s Healthy Babies are Worth the Wait initiative, one hospital sent their perinatal social worker to local OB offices to screen and refer these women, and the rate of substance-exposed infants in their newborn nursery decreased significantly.

Statewide implementation of SBIRT includes the following key steps:

1. Activation of federal Medicaid codes in Kentucky to allow for reimbursement of providers;
2. Selection of a standardized instrument that screens for risk of substance use, mental health symptoms, and intimate partner violence, and is validated for pregnant women;
3. Training on SBIRT strategies and documentation for medical record and reimbursement purposes; and
4. Development of strong referral linkages with case management and treatment providers.

Research has shown that SBIRT can result in healthcare cost savings that range from \$3.81 to \$5.60 for each \$1.00 spent.<sup>14</sup>

- D. Improve Access to Medication Assisted Treatment for Substance Abuse in Pregnancy within Opioid Treatment Programs (OTP). Opioid dependence during pregnancy is complicated by many other substances used (e.g., high rates of daily nicotine use), comorbid mental and medical illnesses, and psychosocial/environmental risk factors that together contribute and adversely affect maternal, neonatal, and longer-term developmental outcomes. All pregnant women with opioid dependence should be counseled on the risks and benefits of available treatment options, including the options of gradual detoxification v.s. maintenance treatment that is part of a comprehensive Opioid Treatment Program (OTC), which must follow state and federal regulations. While detoxification during the pregnancy reduces the likelihood of the infant suffering withdrawal, it is associated with a high likelihood of relapse, often without supports in place to anticipate and address the relapse. The literature shows that methadone maintenance delivered within OTPs (that are also required to deliver on-site counseling, etc.) improves maternal and neonatal outcomes, as compared to no-treatment and medication-assisted withdrawal. Of note, states, including Kentucky, receive federal funds through the Federal Substance Abuse and Prevention Treatment (SAPT) Block grant. SAPT provides state funding to several programs, including two (only two) public OTPs (Bluegrass in Lexington and the Moore Clinic in Louisville). The pregnant patient with a substance use disorder is considered a "priority population" for treatment through SAPT funds, such that each pregnant woman must be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, the pregnant woman can be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services **within 48 hours**, including referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131). However, in practice, treatment is often not available, either due to geography or to the availability of residential or outpatient treatment. Prescribers of both methadone and buprenorphine should be monitored and accountable for outcomes, not just dispensing.
- E. Increase the availability of residential treatment programs for pregnant women and women with children. An estimated 1,000 pregnant women in KY need residential treatment each year. The current capacity for *women* is 441. While pregnant women are given priority access to these beds, often that means being put at the front of a waiting list. Currently, only two programs allow women to bring their children with them. Some of these could be encouraged to specialize in treatment for the substance abusing pregnant woman and her

SEI when both need to be tapered off methadone or other treatment, and allow for parenting training and bonding during the time of treatment.

3. **BIRTH** – The purpose of testing for substance abuse at birth is to identify babies/families at risk and assure that plans are in place for the safety of the infant before discharge and help for the mother after discharge.
  - A. Validated estimates of prevalence in this geographic region are that 9-19% of all births are substance-exposed. Identifying and developing safety plans for that volume of infants is resource-intensive for most communities.
  - B. Hospitals could develop a model protocol regarding screening women and infants for alcohol and other drug exposure at delivery in order to identify infants in need of intervention and protection and mothers in need of treatment. These protocols should use consistent practices to avoid selective screening based on race, socio-economic status or other inappropriate characteristics (universal screening). These protocols should address reporting requirements. CHFS legal counsel could assist in developing a guidance for hospitals regarding the legality of universal screening. Once identified, there should be clear protocols with child protective agencies as to how the infant's safety will be assured.
  - C. Among substance-exposed infants, the incidence of withdrawal (NAS) ranges from 21-94%.<sup>15</sup> However, many of these infants will not manifest symptoms until after the typical 48 hour newborn stay. For that reason, some recommend the substance-exposed infant stay in the hospital at least 4-7 days, even without symptoms, to make it less likely withdrawal will begin at home in an already stressed family situation. Payers generally do not support this practice.
4. **NEONATAL** – all large NICU's in KY have protocols for how to manage neonatal abstinence syndrome (NAS). About half of the infants who go through withdrawal require some form of pharmacotherapy.
  - A. NICU protocols all vary but since there is no solid evidence-based or best practice yet determined, this is acceptable. All NICU's should have standard practices for whichever drugs they use, which are science-based and monitored the outcomes of their protocols. NICU's should track both short and long-term outcomes for these patients since these are not yet evidence-based practices.
  - B. NICU's with protocols all are directed towards shorter length of stays. While this may reduce hospital costs, there are both costs and risks of discharging an infant with NAS to a home environment while still on tapering doses of methadone.
  - C. Consensus Guidelines for Management of Neonatal Abstinence Syndrome (NAS), could be developed, led by the current workgroup, to deal with:
    - i. The local pediatrician's role in managing an NAS infant
    - ii. Appropriate safeguards and criteria for monitoring those infants who are tapered from their opiate withdrawal on an outpatient basis
    - iii. Assure the protocols being used in the NICU follow a science-based approach

- iv. Determine a standard approach to interfacing with DCBS, DPH, and other community resources

There are no established evidence-based treatment protocols for NAS at this time.

Members of the MISA workgroup have agreed to lead the development of KY guidelines.

- D. Most of the NAS infants, after the acute phase, do not need NICU care. In instances where the infant will go home with the mother, the separation during the NICU stay is less than ideal for establishing bonding. Options include a transitional unit or a pediatric bed where the caregiver could stay with the infant, staff are appropriately trained, and the environment is conducive to recovery.
- E. There are residential recovery centers in other states who accept both mother and infant in a home-like atmosphere and manage the medication tapering for both mother and infant while working on parenting, mental health, stress management, arranging housing, and other interventions to promote long term success. (e.g, Pediatric Interim Care Center, WA: <http://picc.net>)

**5. CHILDHOOD** – the most critical part of addressing SEI/NAS is assuring they live and thrive in a SAFE, STABLE, and NURTURING environment during the early years of brain development, when insults and toxic stress could alter their brain structure and future abilities. This will require supports for both mother/caregiver and the infant through the first 2 years of the infant's life. Substance abuse is a chronic relapsing disorder and we should anticipate and plan to manage and treat it as such, since the child is at risk for a chaotic environment during the most critical time of brain development.

- A. Infants who are identified as having been exposed in utero should be followed in a pediatric medical home, receive screening for growth, as well as developmental and social emotional delays, and be referred for further assessment and intervention as appropriate.
  - i. Expansion of the Help Me Grow telephone access developmental screening system (currently in Louisville [United Way] and Corbin [KY AAP grant] would allow parents and caregivers open access to developmental screening (Ages and Stages) This system can be tied into 211.
  - ii. According to the Weisskopf Child Evaluation Center, SEI infants do not need a specialized early intervention program just because they are SEI.
- B. Build systems of Support for the mother/caregiver and the infant through the first 2-3 years should be the priority for the state in order to minimize the adverse effects of substance abuse exposure in utero. Model programs serving substance abusing mothers through pregnancy and their young children through age 3, such as "Safe Babies, Safe Moms" and Parent-Child Assistance Centers in Washington State have shown significant benefits to families served, including more treatment completion, sustained recovery, decreased criminal justice and child protective referrals. These programs include:
  - i. Intensive case management throughout the first 2-3 years of the child's life. Existing KY programs which could be expanded/adapted/ redesigned/coordinated for this emphasis include Kids Now Plus program, START programs, UK's Targeted Assessment Program (TAP) and Community Collaborations for Children (CCC's- DCBS). This Intensive case

- management should include assuring a medical home for both mother and child, adequate food, and safe and stable housing.
- ii. The Case management could be enhanced by parenting training, mental health intervention, peer mentors, and/or trained paraprofessional advocates
  - iii. Ability to get the mother into treatment programs as needed
  - iv. Referral to HANDS, WIC, Depression counseling, Domestic Violence services, other community supports as needed.
  - v. Father involvement when appropriate
  - vi. Other treatment options may include Centering-type group counseling and education, residential homes equipped for mother and baby. Such programs could be piloted in specific areas of high incidence and rolled out according to available funding and proven effectiveness. (see map Appendix 2)
- C. NICU Follow-up is important, but should not be more important than the supports for a local and ongoing safe, stable, and nurturing environment. Literature at this time indicates that very few substance exposed infants (with the exception of alcohol exposure) show developmental delays in the first 2-3 years of life. The learning and behavior problems that SEI are most at risk for do not show up until ages 3-5 when they start school.
- D. Develop training and support for Grandparents caring for Substance Exposed Infants. Caregivers of these infants are often Grandparents. In collaboration with the Dept of Aging Grandparents program, supports should be enhanced to include parenting, developmental intervention, community resources and supports, family counseling, emergency respite, etc.
- E. Affected families should have ready access to health care professionals and supports
- i. 800# call line with peer support
  - ii. Support groups of peers, other parents
  - iii. Access to a physician with experience in substance abuse treatment for mother and baby 24/7
  - iv. Emergency respite in crisis situation
- F. Increase awareness of substance abuse needs within the child welfare system
- i. Require in Standards of Practice that all adults in the household be screened for substance abuse issues using a standardized instrument in each investigation of familial child maltreatment.
  - ii. Train child welfare staff (DCBS staff, foster/adoptive parents, PCC/PCP) in recognizing and referring for substance abuse issues with parents and adolescents.
  - iii. **Develop the capacity and network of treatment options so that families who screen positively have a place to be referred and enter treatment in a timely manner.**
  - iv. Educate DCBS staff in the benefits of MAT to reduce the imposition of requirements that parents end their treatment as a condition of reunification.
- G. Consider repeating the DCBS “drug summits” in communities to educate all community partners on appropriate expectations, laws, pitfalls of drug testing, etc. and develop a common knowledge base among community partners. Could be facilitated through KY ASAP local boards or KY Prevention Network.

### **Section 3: POLICY INTERVENTIONS**

- A. Host a Governor's Summit on Substance Abuse in Pregnancy and Substance-Exposed Infants, to elevate the conversation into a unified ACTION AGENDA. Secretary/Governor could host a summit to develop the state agenda, similar to the recent White House meeting on this topic by ONDCP. KY Office of Drug Control Policy is willing to lead/assist in planning such an event. KY has dozens of agencies and groups working on substance abuse, but they do not cross silos. Summit could gather all groups for learning state of the art/science, and challenge each group to dedicate 25%/33%/50% of their work time in the next 9-12 months to focus on substance abuse in pregnancy and SEI. Groups could explore research and best practices, recommendations around (a) Decreasing substance abuse in pregnancy, (b) maintaining drug-free, safe, stable and healthy environments for SEI in the early years when the brain is being hard-wired, and (c) preventing youth initiation. Then re-convene the group in 9-12 months to develop specific action items. Groups should concentrate on how to re-direct/leverage existing funding/programs rather than ask for more and more funding
- B. Establish a coordinating body to implement the Action Agenda. This coordinating body should be interagency in composition and include Commissioner-level representative who can direct policy as well as experts in and outside of state government. The current KY workgroup could serve as the basis for this group.
- C. Leverage Medicaid options.
- Some states report that 40-50% of Substance-Exposed infants are born to a mother who has already had one or more substance exposed infants. Therefore the proposed Family Planning State Plan Amendment, allowing FP coverage for women <185% of poverty even if not otherwise eligible for Medicaid would also assist Substance-abusing mothers in avoiding repeat pregnancies.
  - Consider a Medicaid waiver to expand access to mental health services for low income women with substance abuse issues beyond the current 60 days to allow access to treatment and case management for the first two years of their infant's life.
  - "Turn On" CMS Code to pay for SBIRT or other counseling tool by providers once training and reporting system established
  - Consider reimbursement for universal screening of pregnant women
- D. Establish baseline measures including cost, prevalence, programmatic interventions, and outcomes of SEI/NAS and Maternal morbidities from Substance Abuse in Pregnancy.
- i. Develop a cost Methodology from HCUP database to be used to track effectiveness of prevention/treatment efforts – see JAMA model.<sup>4</sup>
  - ii. Develop a standardized data set to monitor and track the problem;
    - a. Office of Drug Control Policy recommends establishing an ongoing data match of KASPER and Medicaid data to identify women at risk and proactively intervene.
    - b. Medicaid claims data and hospital discharge data can be used monitor incidence of NAS

- c. If hospital discharge data could be obtained with enough identifiers to establish linkage, data on NAS could be linked with birth certificates to examine the correlation with smoking and other perinatal risk factors.
  - d. Other data sources could be developed to provide insights into this problem
- E. Consider funding a prevalence study of Kentucky births, by testing all births using mother's urine or umbilical cord samples at birth. [similar to recent WV study]. KRS 214.175 authorizes the Cabinet to do anonymous surveys of substance abuse during pregnancy. "The Cabinet may use any state appropriation and any gifts, grants, or federal funds that become available for the purposes of implementing the provisions of this section". Kentucky's most recent prevalence study was completed in 1990, 22 years ago. This updated information would provide a basis for planning prevention and treatment services as well as services for the infants and mothers. The estimated cost for a three month study would depend on the type (urine, umbilical cord) and scope of testing [ e.g. oxydocone in urine requires an additional test beyond normal drug screen]. Unless outside funding can be secured, the cost would have to be weighed against the benefit of knowing this information, especially in light of having data from a prevalence study in neighboring states.

### **KENTUCKY AGENCIES/ORGANIZATIONS ADDRESSING SUBSTANCE ABUSE DIRECTLY**

Dept of Behavioral Health  
KASPER  
Meth Check  
Recovery KY  
Sobriety Treatment And Recovery Teams  
(START)  
Targeted Assessment Project (TAP)  
KIDS NOW Substance Abuse in Pregnancy  
Program  
KY Substance Exposed Infants Workgroup  
Drug Courts  
Office of Drug Control Policy  
KY Agency for Substance Abuse Policy (KY  
ASAP) and 75 local ASAP boards  
Kentucky Prevention Network  
Operation Unite  
America's Promise Alliance  
Project LINK  
KY Association of Addiction Medicine  
KY Coalition for Women with Substance Abuse  
UK CDARS

### **KENTUCKY AGENCIES/ORGANIZATIONS INDIRECTLY ADDRESSING SUBSTANCE ABUSE**

- Dept. for Community Based Services
- Prevent Child Abuse Kentucky
- KY Injury Prevention Research Center (KIPRC)
- HANDS Home Visiting Program
- Early Childhood Mental Health Program (collaboration between DPH and DBH)
- Early Childhood Advisory Council ( through funding HANDS, ECMH, Community early Childhood Councils)
- HIV program
- DPH Prenatal program
- FQHC and Primary Care Association
- Kentucky Perinatal Association
- KY ACOG
- KY AAP

The primary source document for this white paper is: "Substance Exposed Infants: State Responses to the Problem." Substance Abuse and Mental Health Services Administration (SAMHSA). HHS Publication No. (SMA) 09-4369, 2009.

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KY SEED, Early Childhood Mental Health Program, and Substance Exposed Infants Workgroup ( DBH )

## Maternal and Infant Substance Abuse Meeting Attendees

August 17, 2012, Conference Room C

Steve Davis, MD	Acting Commissioner	DPH
Jeff Jamar	Branch Manager	DBHDID
Fran Blevin	Program Administrator	DBHDID
Lynda Sanders	Neonatologist	Central Baptist Hospital
Marvin Miller	Assistant Director	DPH
Joy Hoskins	Director	DWH/DPH
Lisa Lee	Director	Medicaid
Catherann Terry	NCI	Medicaid
Stephen Hall	Commissioner	BHDID
Bill Thompson	Director of S/A-CRCCC	CRCCC
Mary Burnette	Director of Independence House	CRCCC
Charles Kendell	Chief of Staff	DPH
Holly Rollins	Social Worker	Central Baptist
Henrietta Bada	Neonatologist	UK
Connie White	College of Public Health UK	Kentucky ACOG
John O'Brien	Director-MFM	UK-Maternal-Fetal Medicine
Van Ingram	Director ODCP	ODCP
Lori Devlin	Neonatologist	University of Louisville
Cletus Carvalho	Psychiatrist	UK
Audrey Tayse Haynes	Secretary	CHFS

## APPENDIX 1 - BEST PRACTICES FROM OTHER STATES

### FLORIDA<sup>16</sup>

The 2012 Florida Legislature created a Task Force to examine the extent of prescription drug abuse among expectant mothers, as well as the costs of caring for babies with neonatal abstinence syndrome, the long-term effects of the syndrome, and prevention strategies. By the start of the 2013 legislative session the task force will provide lawmakers with a series of policy recommendations on how to combat the problem.

Objectives for the Task Force are:

- Collect and organize data concerning the nature and extent of neonatal abstinence syndrome from prescription drugs in Florida.
- Collect and organize data concerning the costs associated with treating expectant mothers and newborns suffering from withdrawal from prescription drugs.
- Identify available federal, state, and local programs that provide services to mothers who abuse prescription drugs and newborns with neonatal abstinence syndrome.
- Evaluate methods to increase public awareness of the dangers associated with prescription drug abuse, particularly to women, expectant mothers, and newborns.
- Examine barriers to reporting neonatal abstinence syndrome by medical practitioners while balancing a mother's privacy interests.
- Assess evidence-based methods for caring for a newborn withdrawing from prescription drugs and how nurses can assist the mother in caring for their child.
- Develop a compendium of best practices for treating both prescription drug addicted mothers and infants withdrawing, both prenatal and postnatal.
- Assess the current state of substance abuse treatment for expectant mothers and determine what best practices should be used to treat drug addicted mothers.

### LOUISIANA<sup>13</sup>

The **Louisiana Health Assessment Referral and Treatment (LaHART)** tool is a Web-based prenatal behavioral health screen created by the Department of Health and Hospitals (DHH) Birth Outcomes Initiative. LaHART was created to streamline the screening and referral process for pregnant Medicaid eligible women in need of treatment for substance use during pregnancy. The Birth Outcomes Initiative partnered with the Office of Behavioral Health to leverage funding to activate Medicaid billing codes. Louisiana providers are now paid \$50 for conducting prenatal behavioral health screening and brief behavioral intervention. The tool screens for prenatal alcohol, drug and tobacco use, as well as domestic violence. Through the Louisiana Behavioral Health Partnership, DHH has created the infrastructure that the state can use to build a network of providers who will be able to treat women screened and referred through the LaHART tool. In addition, Text4Baby enrollment, automated referral to the state's tobacco quitline and the domestic violence hotline number have been built into the site. The tool has been successfully piloted in New Orleans. The Birth Outcomes Initiative and Office of Public Health are conducting the first phase of LaHART outreach and orientation through June 2012.

## MINNESOTA<sup>1</sup>

The **Circle of Women Project**, modeled after Seattle's Fetal Alcohol Syndrome-Birth to 3 Project (see below), provides intensive in-home visitation and advocacy services for women who are engaging in heavy alcohol and/or drug use during pregnancy and have no involvement with other community services. The Circle of Women Project provides services for the pregnant women and their children for 3 years. The Minnesota Department of Human Services funds two sites for the Circle of Women Project, one serving women in Minneapolis and one serving women of the Leech Lake Reservation in Cass County.

## OHIO<sup>1</sup>

In 1997, the **Sobriety Treatment and Recovery Teams (START) program** was developed and implemented as a response to the dramatic increase of referrals resulting from substance-abusing parents in Cuyahoga County, Ohio. The program views addiction as a disease rather than a lifestyle choice involving potential relapse and varied levels of support services to abstain from drugs. The initial focus of START revolves around treating the parents' addiction upon thorough assessment. After the intake is complete, drug treatment is accessible within 72 hours. To be eligible, the women must have had a positive drug screen. For staffing, START comprises 10 teams who are managed by two supervisors. An advocate and child welfare social worker is assigned to each team, overseeing a caseload of fifteen families. Since most advocates have been in recovery for a minimum of 2 years, they are able to empathize with the obstacles and hardships associated with achieving abstinence. START teams continue to follow up and consult with the treatment providers on a regular basis to monitor progress. **KY now has 4 START sites** through a federal grant.

## VERMONT<sup>17</sup>

Vermont has developed an extensive integrated program for substance-abusing women, led by Dr. Marjorie Meyer, a Maternal Fetal Medicine (OB) Specialist. Resources developed include clinical guidelines, explanations of related laws, templates of forms, criteria for outpatient management, etc. "The most important feature of our work is having a system to communicate between the providers of care for the family in recovery." Available at [www.med.uvm.edu/vchip](http://www.med.uvm.edu/vchip)

## WASHINGTON STATE<sup>1</sup>

- **Prenatal Screening** and Linkages to Services

In 1998, Washington passed legislation directing the Department of Health to develop screening criteria for identifying pregnant and nursing women at risk of having a substance-exposed baby. With input from an Advisory Workgroup and key informant surveys, guidelines for screening pregnant women were developed and widely disseminated to health care providers. The guidelines highlight the benefits of universal screening and strongly urge health care providers to conduct screening on all pregnant women. Providers are advised to use interview-based or self-administered screening tools (examples are provided); the limitations and weaknesses of urine toxicology screens are outlined. The guidelines also stress the need for open, ongoing relationships between patients and providers; provider training on how and when to screen; and a team approach involving the primary provider, clinic nurse, social worker, public health nurse, substance abuse treatment providers, and the patient (Washington State Department of Health, 2002).

Washington also has established the following two noteworthy programs that provide early intervention and other services to pregnant women.

- **Safe Babies, Safe Moms** (Cawthon, 2004; Cawthon & Westra, 2003). In 1999, in accordance with legislative mandate, Washington developed a comprehensive program for mothers with substance use disorders and their young children through age 3. The overall purpose of the project is to improve early identification of pregnant women who are using substances and to increase access to and coordination of health care, substance abuse treatment, and family-oriented intervention services for mothers and their children. Key service components include: targeted intensive case management, residential and outpatient substance abuse treatment, parenting education, housing support services, and child developmental assessments and referrals. Each woman receives an individualized care plan. The project is an interagency collaborative effort, and referrals come from multiple systems, including substance abuse treatment, hospitals, criminal justice (e.g., drug courts and law enforcement), child welfare, and welfare, as well as friends and family. Three pilot sites served 445 women and their children from January 2000 through June 2003. Program evaluation findings demonstrate positive outcomes that include: decreased low birth weight rates, decreased rates of child protective services referrals, decreased criminal justice involvement, and decreased parenting stress levels.
- **Parent-Child Assistance Program (PCAP)**.<sup>16</sup> In 1991, with multiyear funding from the Center for Substance Abuse Prevention (CSAP), Washington developed and implemented the Parent-Child Assistance Program (originally known as the Seattle Birth to 3 Program) to measure the effectiveness of intensive, long-term paraprofessional advocacy with high-risk pregnant women who abuse alcohol or drugs and are disconnected from community service providers. PCAP's goals are to help mothers establish healthy lifestyles, assure children are in safe and stable environments, and prevent future substance-exposed births. Rather than provide direct treatment services, PCAP paraprofessional advocate case managers link families with community services, coordinate services between multiple providers and systems, and help mothers follow through with recommendations of substance abuse treatment providers. This program also has demonstrated positive short-and long-term outcomes in areas such as substance abuse treatment completion, sustained recovery, and prevention of substance use during subsequent pregnancies.

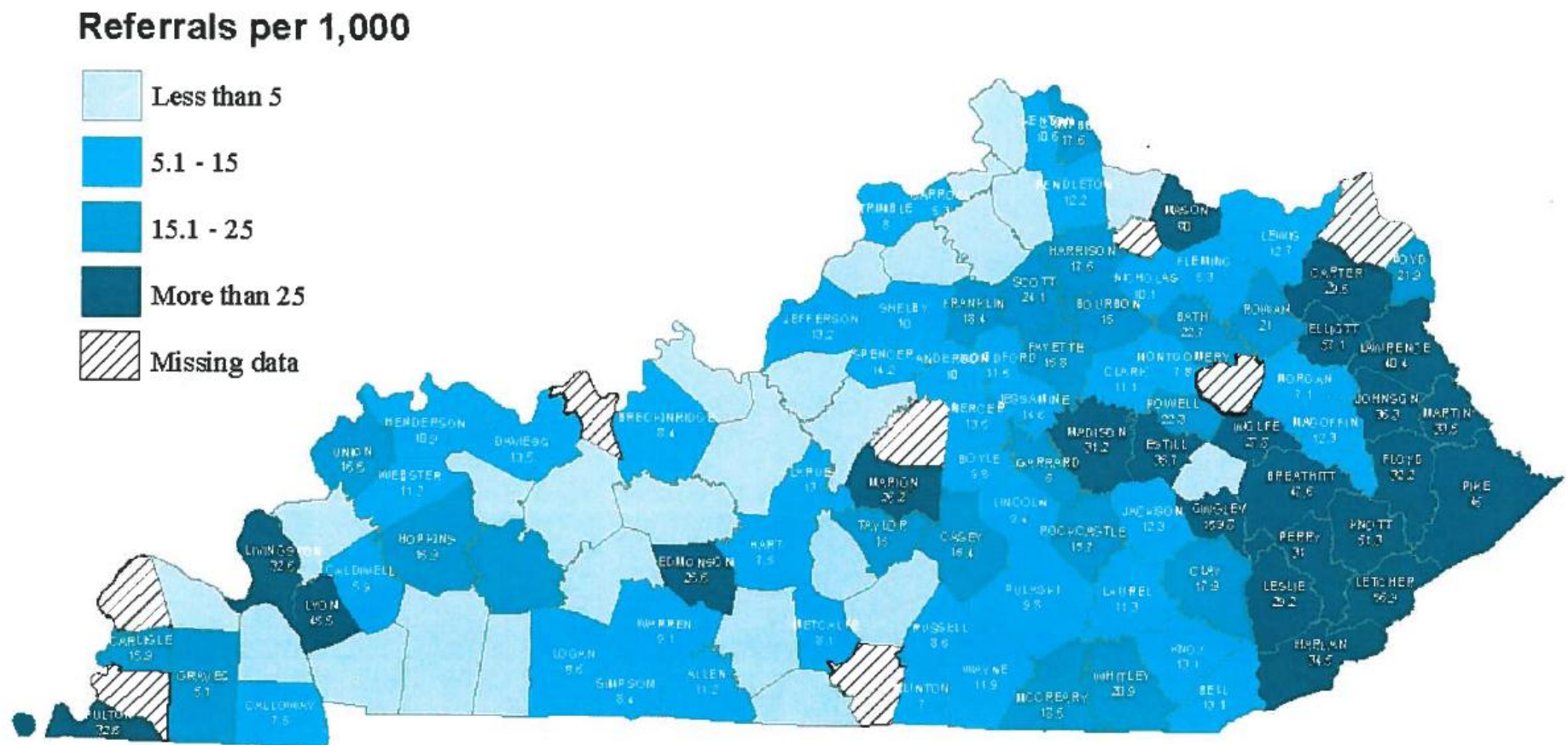
## WEST VIRGINIA<sup>12</sup>

[wvperinatal.org/risk.htm](http://wvperinatal.org/risk.htm)

In 2009, the West Virginia Legislature passed comprehensive maternal-risk screening (Senate Bill 307: “**Uniform Maternal Screening Act**”). The bill required the West Virginia Department of Health and Human Resources, Office of Maternal, Child and Family Health (the State Title V agency) to convene an advisory council to develop a uniform maternal-risk screening tool to help identify pregnant women with potential at-risk pregnancies. The advisory council is also legislated to meet annually to revise the tool as needed. Throughout 2010, the advisory committee worked to modify the West Virginia Prenatal Risk Screening Instrument (PRSI), the risk screening tool developed by the Right From the Start Program, the state perinatal home visiting initiative. The expanded PRSI contains the 4Ps, an opt-in/opt-out for client referral services, and an alert to the prenatal provider that the client may need referral for a maternal fetal medicine consultation. The committee also developed a statewide data collection process to measure the incidents of high-risk pregnancies. The modified PRSI was implemented statewide with all West Virginia maternity service providers on Jan. 1, 2011. The advisory committee continues to meet as necessary to monitor the utilization of the tool and the incidence of high-risk pregnancies. Maternity service providers can access the tool free of charge, online at: [wvdhhr.org/mcfh/WV\\_PrenatalRiskScreeningInstrument2010.pdf](http://wvdhhr.org/mcfh/WV_PrenatalRiskScreeningInstrument2010.pdf).

## APPENDIX 2 Geographic Distribution of SEI who got DCBS referrals<sup>18</sup>

Referrals to Department of Community Based Services  
for Kentucky Newborns Less Than 2 Weeks of Age  
With Substance Abuse Cited As Risk Factor During Investigation



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